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How to get people to comply with COVID-19 public health measures – lessons from cancer screening

November 24, 2020 1.59pm GMT

British Army soldiers prepare to offer a COVID-19 tests as part of Operation Moonshot in Wavertree Tennis centre, Liverpool, England. Peter Powell/EPA

Authors



Ben Young
Research Associate, Behavioural Science, University of Glasgow



Katie Robb
Senior Reader, Behavioural Science and Health, University of Glasgow

The UK government has been accused of stoking fear of COVID-19 and using “scary” graphs to impose public restrictions to control the pandemic. There are many parallels between COVID-19 and cancer: both evoke fear, are viewed as indiscriminate killers, and have prompted large-scale public health responses.

For any public health measure there can be costs to health, society and the economy. There can also be opportunity costs – the potential benefit that is missed when choosing one alternative over another. Questions are increasingly being asked of politicians by doctors, public health experts, mental health advocates and business owners about the “costs” of COVID-19 preventative measures. For example, UK public health experts warned that the Liverpool mass testing pilot, part of Operation Moonshot, could do more harm than good.

In cancer screening, most people are unaware that they are often more likely to be harmed by screening than to benefit from it. Of every 1,000 women screened for breast cancer, five will have their lives saved but 17 will receive unnecessary treatment for cancers that would not have caused them any problems. There is good evidence, however, that the breast cancer screening programme produces greater benefits than harms because of the lives it saves.

Despite the likelihood of harms, public enthusiasm for cancer screening is extremely high and there are frequent public campaigns to expand screening. This is echoed in polls that show strong support for more comprehensive and restrictive COVID-19 measures. This risks creating an environment where policies can be driven by politics and opinion rather than evidence.

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Mass testing of asymptomatic people for COVID-19 involves many unknowns including test performance, intended and unintended consequences, and behaviour change. Cancer screening programmes must have high-quality evidence that the benefits outweigh the harms, reviewed in the UK by the independent National Screening Committee. When comprehensive lockdowns are subjected to similar criteria and scrutiny as other public health measures, some experts have judged the costs to outweigh the benefits.

Fear to control behaviour

Fear is a powerful driver of our behaviour. In a UK survey, almost 60% of people said they were more fearful of cancer than any other disease. Crucially, the relationship between fear and behaviour is not straightforward. A complex combination of beliefs about cancer can lead to adherence or avoidance in response to fear.

Our perceptions of the threat of COVID-19 and how well we feel able to cope with ongoing restrictions, are different now to when the virus first spread. The use of worst-case scenarios to provoke fear and acceptance of lockdowns was undoubtedly effective then, but is being questioned now.



Worst-case scenario. Facundo Arrizabalaga/EPA

Behavioural scientists advised Sage – a group of experts that provides scientific and technical advice to the UK government during emergencies – that people should be treated as “rational actors, capable of taking decisions for themselves and managing personal risk”. This is consistent with the autonomy afforded to people in cancer screening, where informed choice is prioritised over coercion. Acceptance and uptake of a COVID-19 vaccine will need clear health messaging that addresses safety and health concerns to support informed choice.

Only 51% of people in a recent survey in England said they understand the lockdown rules. Communication of complex information is challenging but we can draw on progress made in cancer screening. This has addressed a need to develop clear and concise cancer-screening information that can be easily understood, addressing known barriers and overcoming health-literacy problems.

False reassurance

Among other more obvious harms, cancer screening can promote false reassurance about health. In the US, where lung cancer screening is recommended for high-risk smokers, screened patients receiving negative test results reported feeling less concerned about trying to stop smoking. This could paradoxically increase the risk of developing the condition that the test aims to detect.

Mass testing of asymptomatic people for COVID-19 will generate a large number of negative tests and could promote false reassurance, making people less likely to observe social distancing measures. The ability of the test to detect positive cases, known as the “sensitivity”, means that people with negative results should understand they could have COVID-19, and could get it at any point in the future.

Adherence to self-isolation was very low for close contacts of infected people, and so the government is reducing the isolation period from 14 days to ten days. Making it easier for people to adhere to health measures has been shown to be very effective in cancer screening. There has been greater uptake of bowel screening using new stool sample kits that are easier to complete.

New plans could allow contacts to avoid isolating if they have daily negative tests for a week. However, there is a well-established gap between intentions and behaviour. Cancer screening research is addressing this gap through theory-based practical help, and support with planning and overcoming barriers.

A similar approach with COVID-19 policies could improve adherence. Evidence from cancer screening suggests this is likely to most benefit those who are disproportionately affected by measures, such as those who are more deprived.

It is essential that pandemic response policy decisions involve a consideration of the benefits and harms, behavioural factors and effective communication. This can allow informed, rather than fear-driven, adherence to preventative measures. While cancer screening activity recovers from the impact of the pandemic, we can benefit from the substantial body of research it offers.

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Rob Reddick

Commissioning Editor, COVID-19



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